

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011	
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comment  Complaint Numbers #MS00009031, #MS00009324, MS00009115 An annual and three (3) complaint investigations were conducted on May 18, 2011 in your facility. The results of the complaint investigations were partially substantiated with three (3) related deficiencies cited (110.04, 111.01, and 119.17). These deficiencies are documented on the annual survey Statement of Deficiencies.	M 000	Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors	
M 003	100.02 Codes and Ordinances  Every licensed facility located inside the boundaries of a municipality shall comply with all local municipal codes and ordinances applicable thereto. In addition, each licensed facility shall comply with all applicable state and federal laws.    This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that a copy of the Mississippi Vulnerable Adult Act was posted in the facility.  Findings include:  Observation and staff interview on 5/18/11 at 9:45 a.m. revealed that no posted copy of the Mississippi Vulnerable Adult Act was posted in the facility.	M 003	M003 100.02 Codes and Ordinances  <u>A. Corrective action</u>  The Required posting of the Mississippi Adult Act has been posted in a common area assessable for public viewing.  M005 100.04 Duty to Report  Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document; we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors	8/22/2011
M 005	100.04 Duty to Report	M 005		8/22/2011

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

D29F11

TITLE

(X6) DATE

*Linda Byrd, Executive Director 8/1/11*

If continuation sheet 1 of 28

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 005	<p>Continued From page 1</p> <p>Duty to Report. All fires, explosions, natural disasters, avoidable deaths, or avoidable, serious, or life-threatening injuries to residents shall be reported by telephone to the Licensure and Certification Branch of the licensing agency by the next working day after the occurrence.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to provide documented evidence of reporting serious injury of one (1) of 26 residents (Resident #19) to the Licensure and Certification Branch of the Mississippi State Department of Health as required by regulation.</p> <p>Findings include</p> <p>Record review and staff interview on 5/18/11 at 5:33 p.m. revealed that Resident #19 suffered an injury requiring outside medical intervention (emergency room) on 1/6/11, but no documentation of reporting to the Mississippi State Department of Health as required by regulation was found.</p>	M 005	<p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <p>1. Resident # 19 was reported to state as requested. Resident had multiple skin discolorations without a traumatic cause. Skin discoloration is related to a current blood thinning medical treatment.</p> <p>B. All residents if involved in a fire, explosion, natural disaster avoidable death or avoidable serious or life threatening injury (ies) could be affected by this deficit practice.</p> <p>C. In-Service was given to RCD concerning reporting all reportable incidences when there is a fire, explosion, natural disaster avoidable deaths, or avoidable serious, or life threatening injuries to residents. She verbalized understanding.</p> <p>D. All traumatic injuries will be monitored by the RCD and the ED for the determination of a need to report.</p> <p><b>M053 110.05 Criminal History Record Checks</b></p>	8/22/2011
M 053	<p>110.05 Criminal History Record Checks</p> <p>Criminal History Record Checks.</p> <p>1. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require to be preformed a disciplinary check with the professional licensing agency, if any, for each employee to determine if any disciplinary action has been taken against the employee by the agency, and a criminal history record check on:</p> <p>a. Every new employee of a covered entity</p>	M 053	<p>Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors</p>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 053	<p>Continued From page 2</p> <p>who provides direct patient care or services and who is employed on or after July 01, 2003, and</p> <p>b. Every employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer.</p> <p>2. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history record check have revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted.</p> <p>3. If such criminal history record check discloses a felony conviction; a guilty plea; and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which has not been reversed on appeal, or for which a pardon has not been granted, the applicant/employee shall not be eligible to be employed at the licensed facility:</p> <ul style="list-style-type: none"> <li>a. possession or sale of drugs</li> <li>b. murder</li> <li>c. manslaughter</li> </ul>	M 053	<p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <p>Employees # 1, #2, # 3, #4, #7, #8, and #10 have a copy of the notarized letter on community letterhead identifying the results of the criminal back ground check.</p> <p><b>B. How other employees with the potential to be affected are identified.</b></p> <p>1. The Business Office Director (BOD) or designee audits all current employee files for documented evidence of criminal history checks. If any files are found not in compliance the BOD or Designee evaluates background check and issued employee an appropriate letter.</p> <p><b>C. Measures taken to ensure deficient practice do not recur.</b></p> <p>1. The BOD or designee will keep all documented evidence of criminal history checks in employee files.</p> <p>2. The BOD or designee will in-service all department managers on the requirement and process of ensuring criminal history checks are approved and appropriate evidence in place with notarized letters sent to employees.</p> <p><b>D. How corrective action is monitored.</b></p> <p>The BOD or designee will audit all new employee files for compliance and report findings at the Continuous Quality Improvement (CQI) Meeting.</p>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MS25TR</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>EMERITUS AT TRACE POINTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>501 EAST NORTHSIDE DRIVE CLINTON, MS 39056</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 053	<p>Continued From page 3</p> <p>d. armed robbery</p> <p>e. rape</p> <p>f. sexual battery</p> <p>g. sex offense listed in Section 45-33-23 (g), Mississippi Code of 1972</p> <p>h. child abuse</p> <p>i. arson</p> <p>j. grand larceny</p> <p>k. burglary</p> <p>l. gratification of lust</p> <p>m. aggravated assault</p> <p>n. felonious abuse and/or battery of vulnerable adult</p> <p>4. Documentation of verification of the employee's disciplinary status, if any, with the employee's professional licensing agency as applicable, and evidence of submission of the employee's fingerprints to the licensing agency must be on file and maintained by the facility prior to the new employees first date of employment. The covered entity shall maintain on file evidence of verification of the employee's disciplinary status from any applicable professional licensing agency and of submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual's</p>	M 053		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 053	<p>Continued From page 4</p> <p>suitability for such employment.</p> <p>5. Pursuant to Section §43-11-13, Mississippi Code of 1972, the licensing agency shall require every employee of a covered entity employed prior to July 01, 2003, to sign an affidavit stating that he or she does not have a criminal history as outlined in paragraph (3) above.</p> <p>6. From and after December 31, 2003, no employee of a covered entity hired before July 01, 2003, shall be permitted to provide direct patient care unless the employee has signed an affidavit as required by this section. The covered entity shall place the affidavit in the employee's personnel file as proof of compliance with this section.</p> <p>7. If a person signs the affidavit required by this section, and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed herein, and the conviction or plea has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury as set out in Section § 43-11-13, Mississippi Code of 1972. The covered entity shall immediately institute termination proceedings against the employee pursuant to the facility's policies and procedures.</p> <p>8. The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (7) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the covered entity's hiring officer, or his or her designee, to show mitigating</p>	M 053		

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 053	<p>Continued From page 5</p> <p>circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility.</p> <p>9. The licensing agency may charge the covered entity submitting the fingerprints a fee not to exceed Fifty Dollars (\$50.00).</p> <p>10. Should results of an employee applicant's criminal history record check reveal no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the covered, or his or her authorized designee, confirming the employee applicant's suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any covered entity licensed by the Mississippi Department of Health without the necessity of an additional criminal record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant's criminal background and is not required for a period of two (2) years from the date of the</p>	M 053		

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 053	<p>Continued From page 6</p> <p>letter to conduct or have conducted a criminal history record check as required in this subsection.</p> <p>11. For individuals contracted through a third party who provide direct patient care as defined herein, the covered entity shall require proof of a criminal history record check.</p> <p>12. Pursuant to Section §43-11-13, Mississippi Code of 1972, the licensing agency, the covered entity, and their agents, officers, employees, attorneys and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this section. The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment discrimination suit in which an allegation of discrimination is made regarding an employment decision authorized under this section.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that each employee file had a copy of a notarized letter on facility letterhead for seven (7) of 10 employees notifying them of results of criminal background check (Employees #1, #2, #3, #4, #7, #8 and #10). Findings include: Record review and staff interview on 5/18/11 at 3:10 p.m. revealed Employees #1, #2, #3, #4, #7, #8 and #10 had no copies of notarized letter on facility letterhead of results of criminal</p>	M 053		

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 053	Continued From page 7 background checks.	M 053	<b>M054 110.06 Employee's Health Status</b>	8/22/2011
M 054	110.06 Employee's Health Status  Employee's Health Status. All licensed facility personnel shall receive a health screening by a licensed physician, a nurse practitioner, or a registered nurse prior to employment and annually thereafter. Records of this health screening shall be kept on file in the licensed facility.  This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to provide documented evidence of health screening by a medical doctor, nurse practitioner or registered nurse for one (1) of 10 new hire employees (Employee #9).  Findings include:  Record review and staff interview on 5/18/11 at 2:10 p.m. revealed that Employee #9, hired 7/21/10, did not have a health screening on file.	M 054	<p>Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors</p> <p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <p>1. Employee # 9 has received their completed health status evaluation.</p> <p><b>B. How other employees with the potential to be affected are identified.</b></p> <p>The BOD or designee has audited all current employee files for evidence of health screens prior to employment and annually. All have been placed in compliance.</p> <p><b>C. Measures taken to ensure deficient practice do not recur.</b></p> <p>1. The BOD or designee has in-serviced all department managers on the requirement of Employee Health Screening per state regulations.</p>	
M 055	110.07 Testing for Tuberculosis  Testing for Tuberculosis. The tuberculin test status of all staff shall be documented in the individual's personnel record. The first step of a two-step Mantoux tuberculin skin test shall be performed (administered and read) on all new employees thirty (30) days prior to hire or immediately upon hire. Each Mantoux tuberculin skin test shall be administered and read by personnel trained and certified in the procedure and the results shall be recorded in millimeters of induration. An employee shall not have contact	M 055		

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
M 055	<p>Continued From page 8</p> <p>with residents or be allowed to work in areas of the facility to which residents have routine access prior to the reading and documentation of the first step of a two-step Mantoux tuberculin skin test and completing a signs and symptom assessment. Anyone found to have a positive signs and symptoms assessment (e.g., cough, sputum production, chest pain, anorexia, weight loss, fever, night sweats, especially if symptoms last three weeks or longer), regardless of the size of the skin test, or anyone found to have a positive skin test shall also have a chest x-ray and be evaluated for active tuberculosis by a physician within 72 hours. This evaluation must be prior to any contact with residents or being allowed to work in areas of the facility to which residents have routine access. The results of the first step of the two-step Mantoux tuberculosis testing shall be documented in the individual's record within seven (7) days of employment. Exceptions to this requirement may be made if:</p> <ul style="list-style-type: none"> <li>1. The individual is currently receiving or can provide documentation of having received a course of tuberculosis prophylactic therapy approved by the State Tuberculosis Program for tuberculosis infection, or</li> <li>2. The individual is currently receiving or can provide documentation of having received a course of multi-drug chemotherapy approved by the State Tuberculosis Program for active tuberculosis disease, or</li> <li>3. The individual has a documented previous significant tuberculin skin test reaction.</li> </ul> <p>Individuals with significant Mantoux tuberculin skin tests should be reminded periodically about the symptoms of tuberculosis and the need for</p>	M 055	<p>2. The BOD or designee will monitor all new hire paperwork for appropriate documentation and forward the deficient paperwork to the hiring department manager for proof prior to setting up time card for new employees.</p> <p>3. The BOD or designee will forward to the hiring department manager the need of annual health screening prior to the anniversary date of the employee.</p> <p><b>D. How will the corrective action be monitored?</b></p> <p>1. The BOD or designee will audit all new employee files and all employee files per annual anniversary date and report findings at the community CQI Meeting</p> <p><b>M055 110.07 Testing for Tuberculosis</b></p>	8/22/2011	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 055	<p>Continued From page 9</p> <p>prompt evaluation of any pulmonary symptoms of tuberculosis. A tuberculosis symptom assessment shall be documented as part of the annual health screening. No additional follow-up is indicated unless symptoms suggestive of active tuberculosis develop. Specifically, annual chest x-rays are not indicated.</p> <p>Employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test performed and documented in the employees' personal record within fourteen (14) days of employment.</p> <p>The two-step protocol is to used for each employee who has not been previously skin tested and/or for whom a negative test cannot be documented within the past 12 months. If the employer has documentation that the employee has had a negative TB skin test within the past 12 months, a single test performed thirty (30) days prior to employment or immediately upon hire will fulfill the two-step requirements. As above, the employee shall not have contact with residents or be allowed to work in areas of the facility to which residents have routine access prior to reading the skin test, completing a signs and symptoms assessment, documenting the results.</p> <p>All staff who do not have a significant Mantoux tuberculin skin test reaction shall be retested annually within thirty (30) days of the anniversary of their last Mantoux tuberculin skin test. Staff exposed to an active infectious case of tuberculosis between annual tuberculin skin tests shall be treated as contacts and be managed appropriately. Individuals found to have a significant Mantoux tuberculin skin test reaction</p>	M 055	<p>The identified employees #1 has received one and two Steps TB Test in a timely manner, #2 has documentation of a signs and symptoms assessment signed by a RN, #8 record has been corrected to reflect all of their testing, and #7 have documented evidence in their files of step one and step two with the signs and symptoms forms as required in their file.</p> <p><u>B. How other employees with the potential to be affected are identified.</u></p> <p>The Business Office Director (BOD), or designee will audit all employee files for evidence of appropriate TB documentation and files are corrected.</p> <p><u>C. Measures taken to ensure deficient practice do not recur.</u></p> <ol style="list-style-type: none"> <li>1. The BOD or designee has in-serviced all department directors on the company and state policy regarding TB testing.</li> <li>2. The BOD or designee will monitor all new employee files during orientation and annually for evidence of TB results and forward names to the Resident Care Director and Wellness Nurse for providing the required TB test.</li> </ol> <p><u>D. How will the corrective actions be monitored?</u></p> <ol style="list-style-type: none"> <li>1. The Business Office Director will audit new employee files and employee files upon their annual anniversary date and report findings to the CQI committee.</li> </ol>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 055	<p>Continued From page 10</p> <p>and a chest x-ray not suggestive of active tuberculosis, shall be evaluated by a physician or nurse practitioner for treatment of latent tuberculosis infection.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to provide documented evidence of annual tuberculin skin test for two (2) of 10 established employees (Employees #2 and #7), and failed to provide documented evidence of pulmonary signs and symptoms assessment for two (2) of 10 new hire or previous positive tuberculin skin test employees (Employees #1 and #8).</p> <p>Findings include:</p> <p>Record review and staff interview on 5/18/11 at 3:10 p.m. revealed the following: Employee #1, hired 12/3/07, had a tuberculin skin test placed on 2/24/11 but no results recorded and no second step recorded. Employee #2, hired 3/3/10, was a previous positive for tuberculosis with a chest X ray on 11/30/10 but no signs and symptoms assessment recorded. Employee #7, hired 11/18/09, had an undated signs and symptoms assessment form in the file. Employee #8, hired 9/8/08, had a tuberculin skin test last recorded on 9/26/09.</p>	M 055	M 057 110.09 Records and Reports	8/22/2011
M 057	<p>110.09 Records and Reports</p> <p>Records and Reports.</p> <p>1. The operator shall maintain a record of the residents for whom he or she serves as the conservator or a representative payee. This</p>	M 057	Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 057	<p>Continued From page 11</p> <p>record shall include evidence of the means by which the conservatorship or representative payee relationship was established and evidence of separate accounts in a bank for each resident whose conservator or representative payee is the operator of the licensed facility.</p> <p>2. Inspection reports from the licensing agency, any branch or division thereof by the operator in the licensed facility, and submitted to the licensing agency as required, or when requested.</p> <p>3. Resident records shall contain the following:</p> <ul style="list-style-type: none"> <li>a. Admission agreement(s) and financial statements.</li> <li>b. Residents' rights and licensed facility's rules, signed, dated, and witnessed.</li> <li>c. Medical evaluation and referral from physician or nurse practitioner.</li> <li>d. Current medication record, including any reactions to such medication.</li> <li>e. Social services and activity contacts.</li> <li>f. General information form.</li> <li>g. Representative payee statement, if applicable.</li> <li>h. Physician orders or nurse practitioner orders (including, but not limited to, therapies, diets, medications, etc.) and medication administration records.</li> </ul> <p>The records as described in this section shall be made available to the resident, the resident's</p>	M 057	<p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <p>1. Resident Identified as #1, #2, #5, #6, #19, have the following corrections. #19 has diet on chart. #1, #5, #6, have dated resident rights on file. #2 had on file a witnessed resident rights and facility rules.</p> <p><b>B. How other residents with the potential to be affected are identified.</b></p> <p>1. The Business Office Director (BOD), or designee has audited all current resident administrative files for evidence of signed and dated Residents Rights.</p> <p>2. The Resident Care Director (RCD), or designee has audited all current residents' records for diet orders and all are correct.</p> <p><b>C. Measures taken to ensure deficient practice do not recur.</b></p> <p>1. The RCD or designee has in-serviced all licensed staff on the requirement of obtaining appropriate diet orders.</p> <p>2. The BOD or designee has established a master copy of all required administrative new resident forms and in-serviced all department directors.</p>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 057	<p>Continued From page 12</p> <p>family, or other responsible party for the resident upon reasonable request.</p> <p>4. The facility shall report and comply with the annual MDH TB Program surveillance procedures.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to provide documented evidence of signed, dated and witnessed resident rights and facility rules for five (5) of 19 residents (Residents #1, #2, #5, #6 and #19) and no documented evidence of diet orders for one (1) of 19 residents (Resident #19).</p> <p>Findings include:</p> <p>Record review and staff interview on 5/18/11 at 5:33 p.m. revealed the following :</p> <p>Resident #1 had no dated resident rights on file. Resident #2 had no documented evidence of witnessed resident rights or facility rules on file. Resident #5 had no dated resident rights on file. Resident #6 had no dated resident rights on file. Resident #19 had no signed resident rights, no facility rules and no diet orders documented in the file.</p>	M 057	<p><u>D. How will the corrective actions be monitored?</u></p> <p>1. The RCD or designee will audit all resident physician orders monthly and any found not in compliance will have diet orders obtained from the attending doctor. Findings will be provided to the CQI on a random basis.</p> <p>2. The Business Office Director or designee will audit implementation of the new resident checklist and provide any irregularities to the executive director or designee for corrective actions.</p> <p><b>M059 110.11 Residents Rights</b></p>	8/22/2011
M 059	110.11 Residents' Rights	M 059	Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MS25TR</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>EMERITUS AT TRACE POINTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>501 EAST NORTHSIDE DRIVE CLINTON, MS 39056</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 059	<p>Continued From page 13</p> <ol style="list-style-type: none"> <li>1. Have the right to attend religious and other activities of his/her choice.</li> <li>2. Have the right to manage his/her personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his/her behalf should the facility accept the written delegation from the resident or from his/her responsible party of this responsibility to the facility for any period of time in conformance with State law.</li> <li>3. Not be required to perform services for the licensed facility.</li> <li>4. Have the right to communicate with persons of his/her choice, and may receive mail unopened or in compliance with the policies of the home.</li> <li>5. Be treated with consideration, kindness, respect, and full recognition of his/her dignity and individually.</li> <li>6. May retain and use personal clothing and possessions as space permits.</li> <li>7. May voice grievances and recommend changes in licensed facility policies and services.</li> <li>8. Shall not be confined to the licensed facility against his/her will, and shall be allowed to move about in the community at liberty. Physical and/or chemical restraints are prohibited.</li> <li>9. Not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with State law.</li> </ol> <p>This Statute is not met as evidenced by:</p>	M 059	<p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <ol style="list-style-type: none"> <li>1. Residents Identified as #1, #2, #5, #6, #19, have the following corrections. #19 has diet on chart. #1, #5, #6, have dated resident rights on file. #2 has on file a witnessed resident rights and facility rules.</li> </ol> <p><b>B. How other residents with the potential to be affected are identified.</b></p> <ol style="list-style-type: none"> <li>1. The Business Office Director (BOD) or designee has audited all current resident administrative files for evidence of signed and dated Residents Rights.</li> <li>2. The Resident Care Director (RCD), or designee has audited all current residents' records for diet orders and all are correct.</li> </ol> <p><b>C. Measures taken to ensure deficient practice do not recur.</b></p> <ol style="list-style-type: none"> <li>1. The RCD or designee has in-serviced all licensed staff on the requirement of obtaining appropriate diet orders.</li> <li>2. The BOD or designee has established a master copy of all required administrative new resident forms and in-serviced all department directors.</li> </ol> <p><b>D. How will the corrective actions be monitored?</b></p> <ol style="list-style-type: none"> <li>1. The RCD or designee will audit all resident physician orders monthly and any found not in compliance will have diet orders obtained from the attending doctor. Findings will be provided to the CQI on a random basis.</li> </ol>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 059	<p>Continued From page 14</p> <p>Based on record review and staff interview, the facility failed to provide documented evidence of signed, dated and witnessed resident rights and facility rules for five (5) of 19 residents (Residents #1, #2, #5, #6 and #19) and no documented evidence of diet orders for one (1) of 19 residents (Resident #19).</p> <p>Findings include:</p> <p>Record review and staff interview on 5/18/11 at 5:33 p.m. revealed the following :</p> <p>Residents #1, #5 and #6 had no dated resident rights on file.</p> <p>Resident #2 had no documented evidence of witnessed resident rights or facility rules on file.</p> <p>Resident #19 had no signed resident rights, no facility rules and no diet orders documented in the file.</p>	M 059	<p>2. The Business Office Director or designee will audit implementation of the new resident checklist and provide any irregularities to the Executive Director or designee for corrective actions.</p>	
M 061	<p>111.01 Admission and Discharge Criteria</p> <p>Admission and Discharge Criteria. The following criteria must be applied and maintained for resident placement in a licensed facility:</p> <p>1. Only residents whose needs can be met by the licensed facility shall be admitted. An appropriate resident is primarily an aged ambulatory person who requires domiciliary care and who may require non-medical services, medical services such as medication assistance, emergency response services, and home health services as prescribed by a physician's order and as allowed by law.</p> <p>2. A person shall not be admitted or continue to reside in an licensed facility if the person:</p>	M 061	<p><b>M 061 111.01 Admission and Discharge Criteria</b></p> <p>Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors</p>	8/22/2011

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 061	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>a. Requires physical restraints;</li> <li>b. Poses a serious threat to himself or herself or others;</li> <li>c. Requires nasopharyngeal and/or tracheotomy suctioning;</li> <li>d. Requires gastric feedings;</li> <li>e. Requires intravenous fluids, medications, or feedings;</li> <li>f. Requires a indwelling urinary catheter;</li> <li>g. Requires sterile wound care; or</li> <li>h. Requires treatment of decubitus ulcer or exfoliative dermatitis.</li> </ul> <p>3. Licensed facilities which are not accessible to individuals with disabilities through the A.N.S.I. Standards as they relate to facility accessibility may not accept wheelchair bound residents. Only those persons who, in an emergency, would be physically and mentally capable of traveling to safety may be accepted. For multilevel facilities, no residents may be placed above the ground floor level that are unable to descend the stairs unassisted.</p> <p>4. The licensed facility must be able to identify at the time of admission and during continued stay those residents whose needs for services are consistent with these rules and regulations, and those residents who should be transferred to an appropriate level of care.</p> <p>5. Notwithstanding any determination by the licensing agency that skilled nursing services</p>	M 061	<p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <p>1. Resident Identifier # 17 and # 14 are discharged, resident Number #9 can and does exit independently. Physician statement indicates Resident identifiers #2, #4, #9, #19, and room 207 (Resident identifier # 24 &amp; resident identifier #25 in room 214), in an emergency would be physically and mentally capable of traveling to safety. Resident Identifier #20 Room # 234 is moving to the first floor. Resident identifier #22 Room #239 will be offered the opportunity of relocating to the first floor and if not agreeable to same; will be issued a discharge notice due to being unable to navigate the stairs in case of emergency. Resident identifier #15, and #16, have been added to the 10% identified by M061 111.01 #5. Resident #21, #24 and #25 have received physical therapy evaluations and treatment as ordered by the physicians and is submitted as confirmation for strengthening and gait and balance as they desire to descent the stairs.</p> <p><b>B. How other residents with the potential to be affected are identified.</b></p> <p>1. The Resident Care Director and designee have evaluated all residents for their ability to exit the facility safely and any that fall into this category have been evaluated for appropriate actions.</p>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 061	<p>Continued From page 16</p> <p>would be appropriate for a resident of a personal care home, that resident, the resident's guardian, or the legally recognized responsible party for the resident may consent in writing for the resident to continue to reside in the personal care home, if approved in writing by a licensed physician. Provided, however, that no personal care home shall allow more than two (2) residents, or ten percent (10%) of number of residents in the facility, whichever is greater, to remain in the personal care home under the provisions herein. This consent shall be deemed to be appropriately informed consent as described by these regulations. After that written consent has been obtained, the resident shall have the right to continue to reside in the personal care home for as long as the resident meets the other conditions for residing in the personal care home. A copy of the written consent and the physician's approval shall be forwarded by the personal care home to the licensing agency within thirty (30) days of the issuance of the latter of the two (2) documents.</p> <p>This Statute is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure safety of two (2) of 26 residents (Residents #17 and #19) and four (4) additional complaint residents interviewed (Residents in room # 207, #214, #234 and #239).</p> <p>Based on observation, record review, resident and staff interview, the facility failed to follow admission and discharge criteria for residents by allowing 10 residents of a census of 81 residents (or two (2) more than the allowable 10 percent of current census) to remain in the facility without meeting admission and discharge criteria and without written consent by the resident,</p>	M 061	<p><b>C. Measures taken to ensure deficient practice do not recur.</b></p> <p>1. In-services were conducted by regional team on July 26, 2011 on admission and discharge criteria.</p> <p><b>D. How will the corrective actions be monitored?</b></p> <p>1. Resident care director of Designee will evaluate residents on a semiannual basis or with a significant change for decline that would indicate they could no longer safely exit the facility. Any significant changes will be reported to the Executive Director of designee for collaboration with family, resident and physician for what might be needed for the resident.</p>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MS25TR</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>EMERITUS AT TRACE POINTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>501 EAST NORTHSIDE DRIVE CLINTON, MS 39056</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 061	<p>Continued From page 17</p> <p>responsible party and treating physician (Residents #2, #4, #9, #14, #15, #16, #21, #22, #23 and #24).</p> <p>Findings include:</p> <p>Record review, observation and staff interview on 5/18/11 at 5:33 p.m. revealed Residents #17 and #19 were unable to exit the facility without assistance and that residents in Rooms #207, #214, #234 and #239 were ambulatory with assistive devices, but, could not navigate stairs in case of an emergency.</p> <p>Observation, record review, resident and staff interview on 5/18/11 at 5:33 p.m. revealed the following:</p> <p>Resident #2 was admitted 1/20/10 despite a finding of being legally blind in both eyes on 9/8/10.</p> <p>Residents #4, #9, #14, #15 and #16 had documentation in their files that they were unable to exit the facility without assistance.</p> <p>Residents #21, #22, #23 and #24 lived on second floor of facility and stated to surveyor during resident interviews that they did not feel they could exit down stairs without assistance. No documentation from resident, responsible party or treating physician was found to give consent for these residents to remain in the facility.</p>	M 061	M 063 111.03 Tuberculosis	8/22/2011
M 063	<p>111.03 Tuberculosis (TB)</p> <p>Tuberculosis (TB).</p> <p>Admission Requirements to Rule out Active</p>	M 063	Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 063	<p>Continued From page 18</p> <p>Tuberculosis (TB)</p> <p>1. The following are to be performed and documented within 30 days prior to the resident's admission to the nursing home:</p> <ul style="list-style-type: none"> <li>a. TB signs and symptoms assessment by a licensed physician or nurse practitioner and</li> <li>b. A chest x-ray taken and have a written interpretation.</li> </ul> <p>2. Admission to the facility shall be based on the results of the required tests as follows:</p> <ul style="list-style-type: none"> <li>a. Residents with an abnormal chest x-ray and/or signs and symptoms assessment shall have the first step of a two-step Mantoux tuberculin skin test (TST) placed and read by certified personnel within 30 days prior to the patient's admission to the nursing home. Evaluation for active TB shall at the recommendation of the MDH and shall be prior to admission. If TB is ruled out and the first step of the TST is negative the second step of the two-step TST shall be completed and documented within 10-21 days of admission. TST administration and reading shall be done by certified personnel.</li> <li>b. Residents with a normal chest x-ray and no signs or symptoms of TB shall have a baseline TST performed with the initial step of a two-step Mantoux TST placed on or within 30 days prior to, the day of admission. The second step shall be completed within 10-21 days of the first step. TST administration and reading shall be done by certified personnel.</li> </ul>	M 063	<p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <p>Resident identifier #3, and #11 have received a completed 1<sup>st</sup> and 2<sup>nd</sup> step in a timely manner and records are current. Resident #12 is a Prior positive TB reaction. Notification was received in community on 5/26/10 from physician with order do not give TB test; document on signs and symptoms. This record is attached from chart Article #A. No correction required.</p> <p><b>B. How other residents with the potential to be affected are identified.</b></p> <p>1. The Resident Care Director (RCD) or designee has audited all of the records for evidence of appropriate TB documentation and files found without documentation. Residents have received appropriate testing with the results documented and placed in the record.</p> <p><b>C. Measures taken to ensure deficient practice do not recur.</b></p> <p>1 .The RCD or designees will in-service all licensed nurses on the company policy and state licensure requirement.</p> <p>2. The RCD or designee will audit all new admissions by day 30 of stay to ensure all appropriate action for TB documentation has been done.</p> <p><b>D. How will the corrective actions be monitored?</b></p> <p>1. The RCD or designee will audit all new admissions by day 30 of stay to ensure all appropriate action for TB documentation has been done. Finding will be randomly reported to CQI Meetings.</p>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 063	<p>Continued From page 19</p> <p>i. Residents with a significant TST upon baseline testing or prior significant TST shall be monitored regularly for signs and symptoms of active TB (cough, sputum production, chest pain, fever, weight loss, or night sweats, especially if the symptoms have lasted longer than three weeks) and if these develop shall have an evaluation for TB per the recommendations of the MDH within 72 hours.</p> <p>ii. Residents with a non significant TST upon baseline testing shall have an annual Mantoux TST within thirty (30) days of the anniversary of their last TST.</p> <p>iii. Residents with a new significant TST on annual testing shall be evaluated for active TB by a nurse practitioner or physician.</p> <p>c. Active or suspected Active TB Admission. If a resident has or is suspected to have active TB, prior written approval for admission to the facility is required from the MDH TB State Medical Consultant.</p> <p>d. Exceptions to TST requirement may be made if:</p> <ul style="list-style-type: none"> <li>i. Resident has prior documentation of a significant TST.</li> <li>ii. Resident has received or is receiving a MDH approved treatment regimen for latent TB infection or active disease.</li> <li>iii. Resident is excluded by a licensed physician or nurse practitioner due to medical contraindications.</li> </ul>	M 063		

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MS25TR</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/18/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>EMERITUS AT TRACE POINTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>501 EAST NORTHSIDE DRIVE CLINTON, MS 39056</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 063	<p>Continued From page 20</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that three (3) of 19 resident records reviewed had received a two-step tuberculin skin test within 30 days prior to admission and annually thereafter (Residents #3, #11 and #12) and one (1) of 19 residents did not have documented results of pulmonary signs and symptoms assessment by a licensed physician or nurse practitioner prior to or on the day of admission (Resident #12).</p> <p>Findings include:</p> <p>Record review and staff interview on 5/17/11 from 10:44 a.m. to 2:10 p.m. revealed the following:</p> <p>Resident #3 was admitted 10/4/04 with no history of previous second-step tuberculin skin test or annual tuberculin skin test.</p> <p>Resident #11, admitted 2/29/00, had tuberculin skin test on 6/27/07. The next test given was on 10/4/10.</p> <p>Resident #12 was admitted 5/8/10 with no first or second step tuberculin skin test or signs and symptoms assessment recorded.</p>	M 063	M067 112.01 Meals	8/22/2011
M 067	<p>112.01 Meals</p> <p>Meals. The licensed facility shall provide residents with well-planned, attractive, and satisfying meals at least three (3) times daily, seven (7) days a week, which will meet their nutritional, social, emotional and therapeutic needs. The daily food allowance shall meet the current recommended dietary allowances.</p> <p>1. Meals shall be planned one (1) week in advance. A record of meals served shall be maintained for a one (1) month period. Current</p>	M 067	Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 067	<p>Continued From page 21</p> <p>menus must be posted and dated.</p> <p>2. A record of all food purchases shall be maintained in the licensed facility for a one (1) month period.</p> <p>3. All food served in licensed facilities shall comply with the following:</p> <ul style="list-style-type: none"> <li>a. No game or home canned foods shall be served;</li> <li>b. Other than fresh or frozen vegetables and fruit, all foods must be from commercial sources.</li> </ul> <p>4. All meals for residents who require therapeutic diets shall be planned by a Licensed Dietitian.</p> <p>If a therapeutic diet is prescribed by the physician for the resident, the licensed dietitian shall visit the licensed facility at a minimum of once every thirty (30) days, and shall file a consulting report with the licensed facility.</p> <p>This Statute is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide documented evidence of a licensed dietitian visiting the facility every 30 days to plan meals for seven (7) of 19 residents with therapeutic diets orders (Residents #3, #6, #7, #9, #14, #15 and #16).</p> <p>Findings include:</p> <p>Record review, observation and staff interview on 5/18/11 at 5:33 p.m. revealed Resident #3 had no added salt diet, Resident #6 had a mechanical</p>	M 067	<p><u>A. Corrective action for those found to be affected by the deficient practice.</u></p> <p>1. The Dietitian has been notified of the need to provide dietary consultations for residents identified by resident identifier #3, #6, #7, #9, #14, #15, and #16. Evaluations are complete and documentation is available in resident's records.</p> <p><u>B. How other residents with the potential to be affected are identified.</u></p> <p>1. RCD or designee has audited all resident records for dietary orders and any resident having a special therapeutic diet order has been referred to the dietitian for consultation.</p> <p><u>C. Measures taken to ensure deficient practice do not recur.</u></p> <p>1. The RCD has in-serviced all licensed nurses on the policy of the company and the state regulation for all therapeutic diets to have dietitian consultations.</p> <p>2. The Dietary Management Director has in-serviced all of the dietary staff on the preparation of therapeutic diets and dietary requirements of the residents.</p>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 067	Continued From page 22  soft diet with supplement, Resident #7 had a no added salt, Resident #9 had 1800 calorie ADA diet, Resident #14 had mechanical soft and no added salt diet, Resident #15 had mechanical soft diet and no added salt diet and Resident #16 had a diabetic diet. Dietary staff stated he/she was new and was not aware of all dietary requirements for residents. The service date by dietician posted on bulletin board in kitchen was dated 1/25/11. Dietary staff stated in-service for therapeutic diets with dietician had been scheduled for survey date but had been canceled by dietician.	M 067	<p><u>D. How will the corrective actions be monitored?</u></p> <ol style="list-style-type: none"><li>1. The RCD will audit physician orders monthly and any diet changes will be reported to the dietary manager and the dietitian if determined a consult is required.</li><li>2. RCD will audit all therapeutic diet charts for dietitian consults and therapeutic interventions. Discrepancies will be reported to the Executive Director for action.</li></ol>	
M 068	112.02 Physical Facilities  Physical Facilities.  1. A licensed facility with sixteen (16) or more residents shall obtain a Food Service Permit from the Mississippi Department of Health.  2. A licensed facility with fifteen (15) or fewer residents shall meet the requirements as set forth in the Facility Inspection Report issued by the Mississippi Department of Health.  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to meet minimum requirements of Mississippi Food Code, and failed to provide documented evidence of food sanitation certificate for any food service worker.  Findings include:  Observation and staff interview on 5/18/11 at 10:30 a.m. revealed the kitchen floor had a grease and dirt buildup, and the air conditioning vents had a buildup of grease and dust and all	M 068	<p><b>M 068 112.02 Physical Facilities</b></p> <p>Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors</p> <p><u>A. Corrective action for those found to be affected by the deficient practice.</u></p> <ol style="list-style-type: none"><li>1. All areas have been cleaned.</li><li>2. Safe Serve was completed by the Dietary Service Director on July 11, 2011</li></ol>	8/22/2011

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 068	Continued From page 23  were in need of cleaning. There was no Serv-safe or similar certification for food service staff found.	M 068	<b>B. How other residents with the potential to be affected are identified.</b>  1. All residents had the potential to be affected by this deficient practice.	
M 081	116.02 Bedrooms  Bedrooms.  1. Location.  a. All resident bedrooms shall have an outside exposure and shall not be below grade. Window areas shall not be less than one-eighth (1/8) of the floor area. The window sill shall not be over thirty-six (36) inches from the floor. Windows shall be operable.  b. Resident bedrooms shall be located so as to minimize the entrance of unpleasant odors, excessive noise, and other nuisances.  c. Resident bedrooms shall be directly accessible from the main corridor. In no case shall a resident bedroom be used for access to another resident bedroom nor shall a resident bedroom be used for access to a required outside exit.  d. All resident bedrooms shall be so located that the resident can travel from his/her bedroom to a living room, day room, dining room, or toilet or bathing facility without having to go through another resident bedroom.  e. Resident bedrooms shall house no more than four (4) persons each.  2. Furnishings.	M 081	<b>C. Measures taken to ensure deficient practice do not recur.</b>  1. Switch for vent fan has been replaced.  2. In-services conducted for cleaning by Dietary Service Director.  <b>D. How will the corrective actions be monitored?</b>  1. Dietary Service Director and Dietitian complete monthly surveys of kitchen. Reports are rendered to the Executive Director. Any that are trended are reported to CQI randomly for needed action.	
			M 081 116.02 Bedrooms	8/22/2011

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 081	<p>Continued From page 24</p> <p>a. Single beds shall be provided with good grade mattresses at least four (4) inches thick. Cots and roll-away beds shall not be used.</p> <p>b. Each bed shall be equipped with a pillow and clean linens to include sheets, pillow cases, spreads and blankets. An adequate supply of such linens shall be provided at all times to allow for a change of linen at least once a week.</p> <p>c. Chest of drawers or similar adequate storage space shall be provided for the clothing, toilet articles, and personal belongings of each resident.</p> <p>d. Adequate closet space shall be provided for each resident.</p> <p>e. An adequate number of comfortable, sturdy chairs shall be provided.</p> <p>f. At least one (1) mirror, a minimum of 18" x 24", shall be provided in each bedroom.</p> <p>g. The opportunity for personal expression shall be permitted.</p> <p>h. A resident shall be permitted to use personal furnishings in lieu of those provided by the licensed facility, when practical.</p> <p>3. Floor Area. Minimum usable floor area per bed shall be 80 square feet.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that three (3) of 18 rooms were equipped with mirrors (Rooms A9, A18 and</p>	M 081	<p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <p>1. All Mirrors have been place in rooms A9, A18, 116.</p> <p><b>B. How other residents with the potential to be affected are identified.</b></p> <p>1. Maintenance Director visited all residents' rooms and provided mirrors when requested.</p> <p>2. All newly rented rooms will be inspected by the Community Relations Director or designee prior to renting for complete preparation.</p> <p><b>C. Measures taken to ensure deficient practice do not recur.</b></p> <p>1. The Community Relations Director and the Executive Director were in-serviced on July 26, 2011.</p> <p><b>D. How will the corrective actions be monitored?</b></p> <p>1. All discrepancies in room preparation will be brought to the Executive Director's attention and trends will be brought to the CQI for management at random.</p>	

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 081	Continued From page 25  116).  Findings include:  Observation and staff interview on 5/18/11 at 10:30 a.m. revealed that Rooms A9, A18 and 116 did not have required mirrors in the bedrooms.	M 081		
M 123	119.17 Housekeeping and Maintenance  Housekeeping and Maintenance. The interior and exterior of the licensed facility shall be maintained in an attractive, safe and sanitary condition.    This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that hot water temperatures for residents did not exceed 115 degrees Fahrenheit (F), and facility failed to ensure a safe environment for all residents.  Findings include:  Observation and staff interview on 5/18/11 at 9:30 a.m. revealed hot water temperature in Bathrooms A1 and A15 of memory care unit registered 119 and 118 degrees F, respectively. Subsequent readings after draining and turning down heater revealed the hot water temperature at 11:40 a.m. registered 110 degrees Fahrenheit.  Observation, resident and staff interview on 5/18/11 at 5:33 p.m. revealed that established facility procedures for ensuring proper operation of call pendants were not being followed.	M 123	<p>M123 119.17 Housekeeping and maintenance</p> <p>Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors</p> <p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <ol style="list-style-type: none"> <li>1. Bathrooms in A1 and A15 were monitored daily x 1 week to ensure temperatures remained within regulated guidelines.</li> <li>2. All call pendants are repaired and radio's replaced and programed.</li> <li>3. Automatic door closers are attached to all laundry room doors to maintain safety.</li> </ol>	8/22/2011

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011	
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 123	<p>Continued From page 26</p> <p>Observation revealed that the doors to the laundry on the second floor were propped open with newspapers which could result in an inherent risk of doors closing suddenly on residents. Residents stated they were afraid of being injured by doors.</p> <p>Observation and staff interview on 5/18/11 at 3:25 a.m. revealed the carpet was stained next to the stairwell in the vicinity of Room #240.</p>	M 123	<p>4. Carpeting next to stairwell in the vicinity of room #240 has been cleaned.</p> <p><b>B. How other residents with the potential to be affected are identified.</b></p> <p>1. All residents have the potential to be affected by this deficit practice.</p> <p><b>C. Measures taken to ensure deficient practice do not recur.</b></p> <p>1. Preventive maintenance is in place to monitor room temperatures randomly five rooms per week to ensure temperatures remain within regulated guidelines</p> <p>2. Preventive maintenance schedule is in place to monitor the working order of radio's and call pendants.</p> <p>3. All staff have received in service on laundry room door safety.</p> <p>4. Preventive maintenance schedule is in place to monitor carpeting throughout the facility to ensure it is cleaned regularly and on an as needed basis as the situation warrants in case soiling occurs.</p> <p><b>D. How will the corrective actions be monitored?</b></p> <p>1. Monthly monitored reports will be reviewed at CQI meetings for evaluation for 90 days. If no discrepancies are found, monitoring will be done at quarterly intervals with fire drills, and/or as needed.</p>	
M 136	<p>121.01 The Licensed Entity shall develop and</p> <p>The Licensed Entity shall develop and maintain a written preparedness plan utilizing the "All Hazards" approach to emergency and disaster planning. The plan must include procedures to be followed in the event of any act of terrorism or man-made or natural disaster as appropriate for the specific geographical location. The final draft of the Emergency Operations Plan (EOP), will be reviewed by the Office of Emergency Preparedness and Response, Mississippi State Department of Health, or their designates, for conformance with the "All Hazards Emergency Preparedness and Response Plan". Particular attention shall be given to critical areas of concern which may arise during any "all hazards" emergency whether required to evacuate or to sustain in place. Additional plan criteria or a specified EOP format may be required as deemed necessary by the Office of Emergency Preparedness and Response. The six (6) critical areas of consideration are:</p> <ul style="list-style-type: none"> <li>· Communications - Facility status reports shall be submitted in a format and a frequency as required by the Office of EOP.</li> <li>· Resources and Assets</li> <li>· Safety and Security</li> </ul>	M 136		

## MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MS25TR	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/18/2011
NAME OF PROVIDER OR SUPPLIER  EMERITUS AT TRACE POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE  501 EAST NORTHSIDE DRIVE CLINTON, MS 39056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 136	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>· Staffing</li> <li>· Utilities</li> <li>· Clinical Activities.</li> </ul> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to provide documented evidence of current approval or review of facility Emergency Operations Plan and annual disaster drills, with one on each shift with written minutes of drills.</p> <p>Findings include:</p> <p>Record review and staff interview on 5/18/11 at 5:33 p.m. revealed there was no documented evidence of current approval or review of facility Emergency Operations Plan or annual disaster drill with minutes.</p>	M 136	<p><b>M 136 121.01 Preparedness plan</b></p> <p>Plan of correction is not to be construed as an admission of our agreement with the findings and conclusion in the Statements of Deficiencies or (if applicable) the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements, in this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors</p> <p><b>A. Corrective action for those found to be affected by the deficient practice.</b></p> <ol style="list-style-type: none"> <li>1. Per phone conversation with Nancy Whitehead this tag may be discarded due to transition going on within their office, the plans are not readily available at this time. Per Nancy Whitehead, Dr. Davis stated that they are aware that Trace Pointe does have a valid plan for same. No response for corrections attempted.</li> </ol>	8/22/2011